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HEALTH CARE FACILITY

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PRINTED: 07/01/2011
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN2602	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2011
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MOUNTAIN VIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 1360 BYPASS ROAD WINCHESTER, TN 37398			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
N 000	Initial Comments During the annual Licensure survey conducted on June 27, 2011, through June 29, 2011, at Golden Living Center Mountain View, no deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

TITLE

Executive Director

(X6) DATE

7/15/11

OW0511

If continuation sheet 1 of 1